Commonwealth INDEMNITY PLAN

Benefit Updates and Important Information

SERIES 1
EFFECTIVE
JULY 1, 2004

Commonwealth Indemnity Plan
Administered by UNICARE
www.unicare-cip.com

UniCare®

Updates to the Commonwealth Indemnity Plan Member Handbook

This booklet contains important updates to your Commonwealth Indemnity Plan coverage, effective July 1, 2004. Please keep this booklet, together with the Series 1 Member Handbook, in a convenient place for easy access when you need to refer to your health plan information. If you have any questions about these changes, please call the Commonwealth Service Center at 1-800-442-9300, Monday through Friday between 8:30 a.m. and 5:00 p.m. If you are deaf or hard of hearing and have a TDD machine, contact us on our TDD lines at 1-800-322-9161 or 1-978-474-5163. A customer service representative will be happy to help you.

This benefit update has also been added to the Plan's web site, **www.unicare-cip.com**. This updated information will be included in the next printed revision of the Member Handbook.

Please Note: The page references in this document refer to Member Handbook pages, unless otherwise specified.

Benefit Clarifications

Plan Definitions

- The definition for "**Enteral Therapy**" on page 52 is deleted and replaced with the following:

  "**Enteral Therapy**" – prescribed nutrition that is administered through a tube that has been inserted into the stomach or intestines. Enteral formulas are not covered under the medical plan. Prescription and nonprescription enteral formulas are covered under the prescription drug plan only when ordered by a physician for the medically necessary treatment of malabsorption disorders caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.

- The definition for "**Preferred Vendor"** on page 54 is deleted and replaced with the following:

  "**Preferred Vendor**" – a provider contracted by the Plan to provide certain services or equipment, such as lab services or durable medical equipment. When you use Preferred Vendors you receive these services at a higher benefit level than when you use other providers for these services.

Group Health Continuation Coverage Under COBRA

All of the information regarding COBRA on pages 60-61 of the General Provisions section is deleted in its entirety and replaced with the text below. (The subsection entitled "Conversion to Non-Group Health Coverage" beginning on page 61, which follows the COBRA information in the Member Handbook, remains the same.)

This subsection contains important information about your right to continue group health coverage at COBRA group rates if your group coverage otherwise would end due to certain life events. Please read it carefully.

What Is COBRA Coverage?
COBRA, the Consolidated Omnibus Budget Reconciliation Act, is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called "Qualifying Events." If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

This information explains your COBRA rights and what you need to do to protect your right to receive it. If you have questions about COBRA coverage, contact the GIC's Public Information Unit at 617-727-2310, ext. 801, or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's web site at **www.dol.gov/ebsa**.

Who Is Eligible for COBRA Coverage?
Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an independent right to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee of the Commonwealth of Massachusetts covered by the GIC's health benefits program, you have the right to choose COBRA coverage if:

- You lose your group health coverage because your hours of employment are reduced, or
- Your employment ends for reasons other than gross misconduct

If you are the spouse of an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (known as "qualifying events"):

- Your spouse dies
- Your spouse's employment with the Commonwealth ends for any reason other than gross misconduct or his/her hours of employment are reduced, or
- You and your spouse divorce or legally separate

If you have dependent children who are covered by the GIC's health benefits program, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons (known as "qualifying events"):

- The employee-parent dies
- The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours of employment are reduced
- The parents divorce or legally separate, or
- The dependent ceases to be a dependent child (e.g., is over age 19 and is not a full-time student or ceases to be a full-time student)

How Long Does COBRA Coverage Last?
By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a total of 36 months (as measured from the initial qualifying event) if a second qualifying event – the insured's death or divorce – occurs during the 18 months of COBRA coverage.

You must notify the GIC in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage. Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. **You must provide the GIC with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18-month COBRA period ends in order to extend the coverage.**

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA cost is not paid in full when due (see section on paying for COBRA)
- You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability)
- The Commonwealth of Massachusetts no longer provides group health coverage to any of its employees, or
- Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud)

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

How and When Do I Elect COBRA Coverage?
Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60-day election period, you will lose all rights to COBRA coverage**.

There are several considerations when deciding whether to elect COBRA coverage. COBRA coverage can help you avoid incurring a coverage gap of more than 63 days, which under federal law can cause you to lose your right to be exempt from pre-existing condition exclusions when you elect subsequent health plan coverage. If you have COBRA coverage for the maximum period available to you, it provides you the right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions. You also have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your COBRA coverage ends.

How Much Does COBRA Coverage Cost?
Under COBRA, you must pay 102 percent of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150 percent of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically.

How and When Do I Pay for COBRA Coverage?
If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. **Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period.** After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement.** Payments should be sent to the GIC's address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.**

Can I Elect Other Health Coverage Besides COBRA?
Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance "conversion" policy with your current health plan without providing proof of insurability. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

Your COBRA Coverage Responsibilities

- **You must inform the GIC of any address changes to preserve your COBRA rights.**
- **You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above.** If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- **You must make the first payment for COBRA coverage within 45 days after you elect COBRA.** If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- **You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill.** If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
- **You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:**
  - The employee's job terminates or his/her hours are reduced
  - The employee or former employee dies
  - The employee divorces or legally separates
  - The employee or employee's former spouse remarries
  - A covered child ceases to be a dependent
  - The Social Security Administration determines that the employee or a covered family member is disabled, or
  - The Social Security Administration determines that the employee or a covered family member is no longer disabled

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage. To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P. O. Box 8747, Boston, MA 02114-8747.

Important Plan Information

Healthcare Advisor™

On pages 23-24 of the Managed Care Program section, under the heading "Making Healthy Decisions," the term "Making Healthy Decisions" is deleted and replaced with the term "Healthcare Advisor™."

Minimum Maternity Confinement Benefits

Coverage is provided for inpatient hospital services for a mother and newborn child for a minimum of:

1. 48 hours following an uncomplicated vaginal delivery, and
2. 96 hours following an uncomplicated caesarean section

Any decision to shorten the minimum confinement period will be made by the attending physician in consultation with the mother. If a shortened confinement is elected, coverage will include one home visit for post-delivery care.

Home post-delivery care is defined as health care provided to a woman at her residence by a physician, registered nurse or certified nurse midwife. The health care services provided must include, at a minimum:

1. parent education
2. assistance and training in breast or bottle feeding, and
3. performance of necessary and appropriate clinical tests

Any subsequent home visits must be clinically necessary and provided by a licensed health care provider.

Coverage for Reconstructive Breast Surgery

Members of the Commonwealth Indemnity Plan are eligible for mastectomy benefits. As stipulated by federal legislation, coverage for reconstructive breast surgery in connection with a mastectomy may not be denied or reduced on the grounds that it is cosmetic or that it does not meet the Plan's definition of "medically necessary."

You are covered for reconstructive surgery, including reconstruction of the other breast to produce a symmetrical appearance. You are also covered for prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas. Benefits will be payable on the same basis as any other illness or injury, including the application of appropriate deductibles and coinsurance.

Using Non-Massachusetts Providers

Appendix B is deleted in its entirety and replaced with the following:

What You Should Know When You Use Non-Massachusetts Providers

This appendix contains important information about how the Commonwealth Indemnity Plan pays for services you receive from health care providers located outside of Massachusetts.

Reimbursement to Non-Massachusetts Providers
If you use a non-Massachusetts provider for any reason – including emergency care – you could be subject to balance billing. Balance billing is the practice by health care providers of billing patients for charges that exceed the amount paid by a patient's health plan for services rendered. For example, if your doctor bills your health plan $90 for your office visit and your health plan allows $75 for the office visit, some physicians may balance bill you for the difference of $15.

The following information explains how the Plan reimburses non-Massachusetts providers and how you may be able to manage or avoid balance billing by these providers.

The Plan pays non-Massachusetts providers according to fee schedules that establish the reasonable and customary allowed rates for payment of services. The payments in the fee schedules are consistent with what other plans pay providers. Charges in excess of the fee schedule amounts will not be considered for payment, as they will exceed these allowed amounts. A provider might balance bill you for the difference between the payment made by the Plan according to the fee schedules and the amount the provider charged.

Ways to Avoid Balance Billing
Here are two ways you can manage or even avoid balance billing:

- ***Use Massachusetts Providers for Your Health Care Whenever Possible*** – If you are planning any elective health care services, or need to schedule a medical or surgical procedure, you should consider using Massachusetts providers for that care whenever possible. These providers are prohibited by Massachusetts law from balance billing members of the Commonwealth Indemnity Plan for amounts above the allowed amounts established in the fee schedules.

  The Plan encourages you to plan ahead, scheduling medical care in Massachusetts before you go away, or upon your return. This will guarantee that you don't get balance billed.

- ***Discuss the Balance Bill with Your Non-Massachusetts Provider*** – Ask your provider to consider accepting the allowed amount from the Plan as payment in full for his or her services. The Commonwealth Indemnity Plan's fee schedules for out-of-state providers are intended to provide adequate compensation for services, usually at a level similar to – and sometimes higher than – what providers are receiving from many other health insurance plans in the area. Additionally, the Plan pays providers promptly; nearly 100 percent of provider claims are paid within 14 days of their receipt.

Using the Plan's Out-of-state Contracted Providers to Avoid Balance Billing
You or your eligible dependent may be able to participate in the Plan's program to help you avoid balance billing if you meet one of the following criteria:

1. you reside outside of Massachusetts – either permanently or for more than four consecutive weeks of the year – and receive services from non-Massachusetts providers, or
2. you have an eligible dependent who attends school outside of Massachusetts who receives services from non-Massachusetts providers

The Plan allows access to contracted providers outside of Massachusetts that you or your eligible student dependent can use for health care services, depending on where you or your dependent lives. These providers accept the Plan's fee schedules as payment in full and agree not to balance bill you. For more information on these contracted providers and how to use them, contact the Plan (see information below).

If You Live Out-of-state Temporarily
If you or your eligible child dependent plan to reside outside your home state for more than four consecutive weeks of the year, please call the Commonwealth Service Center at **1-800-442-9300** to report your new address. Or download and complete the temporary change of address form from the Plan's web site at **www.unicare-cip.com** from the "Forms and Documents" web page and mail the form to the Plan.

For More Information
For additional information about how to avoid being balance billed by non-Massachusetts providers, contact the Commonwealth Service Center at **1-800-442-9300.** You can also e-mail the Plan from its web site at **www.unicare-cip.com**; click on "Contact Us."

Plan and Health Information Resources

Resources Available on the Plan's Web Site

The Plan's web site, **www.unicare-cip.com**, offers you an extensive range of Plan-related and general health care information and resources. These resources give you the ability to:

- check the status of your claims
- find out about the Plan's discounts on a variety of health-related products and services
- access information to help you understand and manage various health conditions and treatment procedures with the Healthcare Advisor™. This resource also provides profiles of health care facilities to help you assess where to best receive care, based on your needs and preferences.
- learn what's being done to improve patient safety in hospitals and how this information may help you select a hospital. Find out the extent to which hospitals in your area have implemented safety initiatives developed by the Leapfrog Group for Patient Safety and how frequently they have performed certain procedures.
- research medical information with the Healthwise Knowledgebase, an extensive online database of unbiased, up-to-date medical information
- access important Plan information, such as notification requirements
- view your Member Handbook and detailed descriptions of certain Plan benefits
- search for PLUS physicians and hospitals, as well as preferred vendors for services such as laboratory services and products such as durable medical equipment and medical supplies
- order Plan materials, e-mail the Plan and more

Express Scripts, Inc.
Prescription Drug Program

Effective July 1, 2004

Benefit Changes

The information in this update contains important changes to the prescription drug benefit described on pages 64-68 of the Series 1 Member Handbook.

1. On page 64, under **Step Therapy**, in the list of prescription drugs requiring Step Therapy: the drug Glucophage XR® is removed from the list and the following drugs are added:

   Aciphex®, Accolate, Aceon®, Arthrotec®, Atacand®, Avalide®, Elidel®, Humira®, Kineret®, Lexxel®, Lexepro®, Lotrel®, Micardis®, Mobic®, Monopril®, Ponstel®, Protopic®, Strattera®, Tevetan®, Uniretic®, Zyflo®

2. On page 67, under **Prior Authorization**, Cerezyme® is removed from the list of drugs that require prior authorization.

   The drugs Tazorac®, Regranex®, Penlac®, Amevive®, Forteo® are added to the list of drugs that require prior authorization.

   The line, "For members over the age of 18: Dexedrine®, Desoxyn®, Adderall®", is removed in its entirety.

3. On page 68, in the **Exclusions and Limitations section**, the drugs Cialis® and Levitra® are added to the examples of drugs for which quantities may be limited.

United Behavioral Health

Mental Health, Substance Abuse and Enrollee Assistance Programs

Effective July 1, 2004

The following information is provided as a clarification to the information found in your Commonwealth Indemnity Plan Member Handbook. This benefit update is effective July 1, 2004.

Part I – How to Use This Plan

Please replace the section titled "Let Us Show You the Benefits" in its entirety within "Part I – How to Use This Plan" on page 71 in your Commonwealth Indemnity Plan Member Handbook with the following:

The following describes your mental health, substance abuse and EAP benefits under the UBH plan. Please read it carefully before you seek care to ensure that you are receiving maximum benefits. The chart on pages 78-79 provides a brief overview of your benefits; however, it is not a detailed description and has changed slightly. A more detailed description of your benefits is found in Part III on pages 80-83. Words in italics in this description are defined in the "Definitions" section in Part II.

This is the "Description of Benefits" for your mental health, substance abuse and EAP services. While it is a full description of the available benefits under this plan, it is not the "Evidence of Coverage," the legal policy document that UBH submits to the Massachusetts Division of Insurance (DOI). The "Evidence of Coverage" governs the plan and includes state and federal mandated language, required disclosures to the Office of Patient Protection, continuation of coverage provisions as directed by state and federal law, and other required plan disclosures. The full "Evidence of Coverage" is available in electronic form and can be downloaded from the UBH web site www.liveandworkwell.com (access code: 10910). If you would prefer a paper copy of this document, please send a written request to UBH at the address provided on page 73, and a copy will be sent to you free of charge.

Part III – Benefits Explained

The subsection titled "Out-of-Network Benefits" is deleted in its entirety within section "Part III – Benefits Explained" on page 82 of your Commonwealth Indemnity Plan Member Handbook and replaced with the following:

Out-of-Network Benefits

Outpatient Care – Out-of-network outpatient visits 1 through 15, which are deemed to be *covered services*, are paid at 80% of UBH's *allowed charges*, after your $150 annual *deductible* is met. Outpatient visits 16 and over that are *precertified* are paid at 50% of UBH's *allowed charges*. Out-of-network outpatient visits 1 through 15 do not require *precertification*, however, all outpatient out-of-network visits beyond session 15 require *precertification* with a *UBH Clinician* (call UBH toll free at 1-888-610-9039).

In-Home Care – Included in outpatient care visits and accumulates with other outpatient visits to determine the appropriate level of reimbursement. Visits up to session 15, which are deemed to be *covered services*, are paid at 80% of UBH's *allowed charges*, after the appropriate annual *deductible* has been met. In-home care beyond session 15 requires *precertification*. *Precertified* out-of-network outpatient visits 16 and over are paid at 50% of UBH's *allowed charges*.

Intermediate Care – *Intermediate care*, which is deemed to be a covered service, is paid at 80% after the appropriate annual *deductible* has been met.

Inpatient Care – Out-of-network inpatient care, which is deemed to be a *covered service* for mental health care or substance abuse treatment, is paid at 80% in a general hospital, psychiatric hospital or substance abuse facility.

Each admission to a hospital or facility is subject to a $150 inpatient *deductible* per person in addition to the calendar year *deductible*. Failure to *precertify* inpatient care is subject to a *non-notification penalty* of $200 if the UBH case manager determines that the care is a *covered service*. No benefits will be paid if it is found not to be a *covered service*.

Drug Testing – There is no coverage for out-of-network drug testing.

See pages 83-85 for a list of Exclusions.

Commonwealth
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Important Information Enclosed
Please Read